Department of Health and Human Services

EMPLOYEE CLAIM FOR LOSS OR DAMAGE TO PERSONAL PROPERTY

Complete this form in triplicate in accordance with Chapter 4-35, General Administration Manual, and submit the original with the supporting documents to your supervisor or to the appropriate Claims Investigating Officer.

NAME OF CLAIMANT	ADDRESS *(City, State, and Zip Code)*

SERVICE OR STAFF OFFICE	DIVISION OR BRANCH	TEL. NO. AND EXT.

LOCATION OF LOSS OR DAMAGE	DATE OF LOSS OR DAMAGE	TOTAL AMOUNT OF CLAIM
		$

DESCRIPTION OF PROPERTY *(Use additional sheet, if necessary)*

ITEMIZED LISTING	DATE ACQUIRED	PURCHASE PRICE OR VALUE WHEN ACQUIRED	VALUE WHEN LOST OR DAMAGED	ESTIMATED REPAIR OR REPLACEMENT COST
		$	$	$
	TOTAL			

TYPE OF CLAIM *(Check appropriate block and give brief statement of circumstances)*

☐ LOSS

☐ DAMAGE

WAS PROPERTY INSURED?

☐ YES *(If "yes," give name of insurer)*

☐ NO

HAS CLAIM BEEN MADE ON INSURER? *(If "yes," itemize amount)*

☐ YES

☐ NO

DID LOSS OR DAMAGE OCCUR WHILE PROPERTY WAS IN POSSESSION OF A CARRIER?

☐ YES

☐ NO

HAS CLAIM BEEN MADE ON THE CARRIER? *(If "yes," give name of carrier and itemize amount collected)*

☐ YES

☐ NO

CRIMINAL PENALTY FOR PRESENTING A FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS: Fine of not more than $10,000 or imprisonment for not more than 5 years or both (see 62 Stat. 698, 749; 18 U.S.C. 287. 1001).

CIVIL PENALTY FOR PRESENTING A FRAUDULENT CLAIM: The claimant shall forfeit and pay to the United States the sum of $2,000, plus double the amount of damages sustained by the United States (see R.S. Sec. 3490, 5438; 31 U.S.C. 231).

CERTIFICATION

I certify that I make this claim with full knowledge of the penalties for wilfully making a false claim and that I am entitled to any payments.

SIGNATURE OF CLAIMANT	DATE

IN WITNESS of the above claim, I, on behalf of the claimant, do hereby certify that this claim is being made with full knowledge of the penalties for wilfully making a false claim.

SIGNATURE OF OTHER CLAIMANT	RELATIONSHIP *(If any)*	DATE

HHS-481
3/81

PERSONAL CUSTODY PROPERTY RECORD/HAND RECEIPT

PROPERTY ISSUED TO:	OPDIV/STAFFDIV	ION/BRANCH	LOCATION: RM./BLDG.
NAME: (LAST) (FIRST) (MI)			

Statement of Responsibility

I have received the item(s) listed below on the date indicated. I accept personal responsibility for the property and will surrender it upon demand, transfer, or separation from the Government. I further understand that failure on my part to exercise responsibility for the care and protection of the item(s) listed below could result in pecuniary liability established in accordance with HHS Materiel Management Manual § 103-1.5008(b).

DESCRIPTION–INCLUDING MAKE, MODEL, SERIAL NUMBER AND ACCESSORIES	
	NAME OF PERSON RECEIVING PROPERTY TELEPHONE NUMBER
	SIGNATURE DATE
	RETURNED DATE
	RECEIVED-SIGNATURE OF CUSTODIAL OFFICER
	ITEMS ARE TO BE RETURNED TO:
NAME OF ISSUING PROPERTY REPRESENTATIVE SIGNATURE	ISSUING OFFICE LOCATION TELEPHONE NUMBER

HHS 439 (REV. 7/83)

GPO 900-897

INVENTORY ADJUSTMENT

1. PROPERTY ACCOUNT	3. VOUCHER NUMBER
2. ACCOUNTABLE OFFICER	4. DATE

5. LINE ITEM	FSC OR STOCK NO.	DESCRIPTION OR NOMENCLATURE	UNIT	UNIT COST	OVERAGE		SHORTAGE	
					QUAN.	TOTAL COST	QUAN.	TOTAL COST
		TOTAL						

6. REMARKS:

Preparing Official _____ _____
(Signature) *(Date)*

7. ACTION OF APPROVING AUTHORITY : *The line items deleted are to be listed on a Report-of-Survey. The remaining line items are approved for adjustment. (See Exhibit X-31A Instructions)*

Approving Official _____ _____ _____
(Signature) *(Title)* *(Date)*

DHHS-365 12/80

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REQUEST FOR TRANSPORTATION SERVICE G/B/L No._____

INSTRUCTIONS:
REQUESTING OFFICE – Prepare in triplicate. Retain one copy for reference and forward the original and one copy to appropriate Shipping Officer. (Note: Shipments will be made by the mode which will result in the lowest overall cost to the Government, unless a specific delivery date is required. If a specific delivery date is required, or premium transportation is requested it must be justified. Signature by the approving official will denote certification of the required delivery date and/or that he approves the justification for using a more expensive mode.)
SHIPPING OFFICER – *After carrier has completed pickup of shipment, retain original copy until copies of GBL's* are transferred to record centers. The copy may be used for administrative purposes as needed.

1. SHIPMENT IS REQUESTED OF THE FOLLOWING: (Indicate the number of boxes, crates, cans, etc. approximate weight, and complete description of article(s) to be shipped, including type, size, and trade name if appropriate)

(If Additional Space is Needed, Use Reverse Side)

2. FROM: (Building, Room No., Street, City, and State or Country)	3. TO: (Consignee Name, Street, City, and State or Country)

4. PROPERTY IS: ☐ GOVERNMENT OWNED ☐ OTHER *(Specify)*

5. PROPERTY CLEARANCE (Signature of Accountable Officer or Other Official and Date)

6. SHIP BY: ☐ GOVERNMENT BILL OF LADING ☐ COLLECT ☐ COMMERCIAL BILL OF LADING
☐ COMMERCIAL BILL OF LADING FOR CONVERSION TO GBL AT DESTINATION

7. SHIPMENT WILL REQUIRE: ☐ PACKING ☐ CRATING ☐ OTHER *(Explain in 11)*

8. REQUESTED BY: (Name, Office or Division, Telephone No. and Extension)

9. CHARGES TO BE BILLED TO: (Exact Fiscal Office Address)	10. APPROPRIATION AND CAN NUMBERS

11. ADDITIONAL INFORMATION, INSTRUCTIONS, AND/OR JUSTIFICATION FOR OTHER THAN LOWEST COST MODE

12. APPROVED BY: (Signature of Approving Official) (Title) (Date)

FOR USE OF SHIPPING ACTIVITY ONLY

DATE SHIPPED		MODE OF TRANSPORTATION	
NUMBER OF PIECES	TOTAL WEIGHT	LABOR (Hours)	LABOR CHARGE

NOTES:

☆ U.S.G.P.O.: 1988 - 521-867/00197

Department of Health and Human Services

REQUEST FOR LABORING, MATERIALS HANDLING AND TRUCKING SERVICES

Date of request

Submit original and 2 copies to Labor SECTION

FROM (Agency, Bureau, Division)		NAME OF PERSON REQUESTING SERVICE	
ROOM	BUILDING	TELEPHONE	
Check service requested ☐ TRUCKING ☐ LABORING SERVICE ☐ MATERIALS HANDLING	Date of service	From (location)	Appropriation
	Time of service	To (location)	Allotment

DESCRIPTION OF SERVICE REQUESTED (specify items to be transported or work to be performed):

REQUESTED BY	TITLE
APPROVED BY	TITLE

FOR ADMINISTRATIVE USE ONLY:

	TOTAL HOURS CHARGED	RATE
Labor service		
Truck Driver		
Truck Rental		
Materials Handling service		

HHS-20 (Rev. 4/88)

REQUEST TO USE GOVERNMENT FURNISHED VEHICLE FOR TRANSPORTATION BETWEEN DOMICILE AND PLACE OF EMPLOYMENT

NAME AND TITLE	STATION

PLACE OF EMPLOYMENT-DOMICILE (show addresses and distance between)

The characteristics of the field work to be performed and the further circumstances requiring the use of a Government vehicle between this officer's or employee's domicile and place of employment in the performance of the described field work are as follows:

X

Recommend the above named person be permitted to use a Government furnished motor vehicle for transportation between domicile and place of employment for the period from _____, 19__ to _____, 19__ when warranted by the circumstances or conditions stated above. The characteristics of the field work are such that the interests of the Government require that this person be permitted to use a Government vehicle between domicile and place of employment.

SIGNATURE AND TITLE OF RECOMMENDING OFFICIAL	DATE

APPROVAL

SIGNATURE AND TITLE OF AUTHORIZING OFFICIAL	DATE

FORM HHS-16 (REV. 6/83)

PRIVACY ACT NOTICE FOR EMPLOYEES

Authority

This information is provided pursuant to the Privacy Act of 1974. Section 5 of U.S. Code 638 permits the use of a passenger motor vehicle only for official purposes, which does not include domicile/place of employment travel, but does include use by medical officers on out-patient medical service and others when approved by the head of the Department. Subpart 103-38.05 of the HHS Materiel Management Manual provides policy on the use of vehicles.

Purposes and Uses

The principal purposes of the "Request to Use Government Furnished Vehicle for Transportation between Domicile and Place of Employment", Form HHS-16, is to document the employee's request, the recommended approval, and the approval for use of a Government furnished vehicle between domicile and place of work. The information may be used (a) by Federal agencies in reviewing vehicle utilization, (b) by Federal, State or local agencies for investigating or prosecuting a violation or potential violation, (c) for statistical information in which personal identification would be excluded, or (d) for other routine duties in accordance with 5 U.S.C. 552a.

Effects of Nondisclosure

Omission of an item may result in disapproval of request. Falsification of entries may be grounds for disciplinary action including suspension. The disclosure of the information requested is voluntary.

Department of Health and Human Services

Request for Property Action

Initiator Organization, Mailing Address, Contact Name, Telephone Number, Physical Location of Property:	Date of Request: Organization Can No./Property Document No./Admin Code or PMO/ Custodial Location Code

Action Requested (Check One)

☐ Transfer: Receiving CAN# New Location# ☐ New Receipt ☐ Turn In ☐ Disposition Instructions (EXPLAIN IN DETAIL - Use reverse side of form)

Barcode/ Decal Number	Serial Number	Description of Property (Noun Name, Mfg Name, Model Number, Stock Number)	Qty	Unit of Issue	Cond. (see below)	Unit Cost	Total Cost

Special Processing Requirements:

Project Officer Assigned ___ Yes ___ No PO Signature: _____ Date: _____

IRM Clearance ___ Yes ___ No IRM Signature: _____ Date: _____

*See Below**

Signature of Property Custodial Officer/Initiator (PCO)	Date:	**Property Section Only**	
Signature of Receiving Official	Date:	Property Custodial File Update/Final Property Action	
Signature of Property Management Officer (PMO)	Date:	Initials of Property Technician/Accountable Officer	Date:

Property Voucher Control Number

Request will be returned if not provided

Condition Codes: (see FPMR 101-43.48 for definitions)

1 = Unused - Good	4 = Used - Good	7 = Repairs Required - Good
2 = Unused - Fair	5 = Used - Fair	8 = Repairs Required - Fair
3 = Unused - Poor	6 = Used - Poor	9 = Repairs Required - Poor
X = Salvage	S = Scrap	

Distribution

Original - Property Management Branch
1 Copy - Retained by Requester
1 Copy- Retained by PCO
1 Copy - Retained by PMO
1 Copy Transfer Receiving Office

**IRM Equipment certified free of commercial software/sensitive information*

HHS-22 (Rev. 8/93)

*U.S. GOVERNMENT PRINTING OFFICE: 1976—624-254

INSTRUCTIONS: Prepare in quadruplicate. The "receiving report" of the purchase order shall be used for the initial delivery. Use this form HEW-12 as a partial receiving report for subsequent receipts.

HEW-12
Rev. 9-69

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
RECEIVING REPORT

Name of Ordering Office	Received from *(Name of Vendor)*	Date Prepared	P.O. No.
			☐ Complete; ☐ Partial Requisition No.

ARTICLE	QUANTITY	UNIT PRICE	AMOUNT

REMARKS

Received the above articles in good condition and in the quantities indicated except as noted under "Remarks."

Date *Signature of person accepting shipment*

ACCOUNTING USE ONLY	RT	Effective Date MO. DAY YR.	Trans. Code	REV	MOD	Orig. Document Code / Number	Current Document Code / Number

Geog.	FY	CAN	Obj. Maj.	Class Sub	AMOUNT	Fed./ Non-Fed.	Vendor Code-Prim. Recip.	Vendor Code-Sec. Recip.

Pay/Coll. Doc. No.	PPBS Category	PPBS Activity	Case II	Bal. Pay	Gen. Ledger Dr.	Gen. Ledger Cr.	Type of Service	
								AUDIT COPY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PERSONAL PROPERTY – LOAN RECORD

LENDING AGENCY'S NAME, ORGANIZATION AND ADDRESS:	CUSTODIAL POINT CODE	ACCOUNTABLE AREA CODE	DATE

BORROWER'S NAME AND ADDRESS *(Institution, Organization or Individual)*	LOAN PERIOD
	☐ SIX MONTHS ☐ ONE YEAR

STOCK NUMBER	DESCRIPTION *(prop. no., Mfg. Ser. no, Model no)*	UNIT	QUANTITY	VALUE	COND.

SIGNATURE OF CUSTODIAL OFFICER:	DATE:
SIGNATURE OF CUSTODIAL OFFICER:	DATE:
SIGNATURE OF APPROVING OPERATING AGENCY HEAD:	DATE:

I hereby certify that the necessary records have been established and appropriate annotations have been made on the inventory records to maintain control of property by location.

Signature of Accountable Officer _____ Date _____

The property is hereby loaned for official use for the period commencing _____ and ending _____, unless terminated at an earlier date. The borrower agrees to be responsible for any damage and/or repairs necessary as the result of usage, prior to return of property. All transportation costs incident to delivery or return of property will be at the borrower's expense. Justification for loan must be attached to this record. The signature of the borrower indicates his acceptance of the property under the terms cited above and those contained in HHS MM § 103-27.56.

Signature of Borrower _____ Date _____

HHS FORM 557 (6/81)

DISTRIBUTION INSTRUCTIONS

1. Prepare form in quadruplicate.

2. Forward all copies through the Administrative Officer to the Accountable Officer.

3. The second and third copies will be returned to the lender.

4. The fourth copy will be sent to the borrower.

5. On return of the property, the lender shall indicate its return on the third copy and returned to the Accountable Officer.

DHHS ACCIDENT REPORT

To be used to report accidents including exposures to chemical, biological or radiological agents and property damage. PLEASE PRINT. Do NOT fill in shaded blocks.

REPORT DATA

1. ORGANIZATION

2. CASE NUMBER — YEAR / NUMBER

3. SEQUENCE NO.

4. TYPE OF REPORT
I - INITIAL
S - SUPPLEMENTAL*
C - CORRECTED*
*Use same case no. see initial report

5. TYPE OF ACCIDENT
P - PROPERTY ONLY
I - INJURY/ILLNESS
B - BOTH

PERSONNEL INVOLVED DATA

6. NAME *(Last, first, middle initial)* PLEASE PRINT

7. SOCIAL SECURITY NUMBER

8. AGE

9. SEX M F

10. PAY PLAN

11. GRADE

12. STEP

13. SERIES

14. OCCUPATION

15. YEARS OF SERVICE In present position

16. PERSONNEL STATUS
A - CIVILIAN EMPLOYEE
B - VISITING SCIENTIST
C - CONTRACTOR
D - HOSPITAL PATIENT
E - OUTPATIENT
F - COMMISSIONED OFFICER
G - OTHER FED. EMPLOYEE
H - STATE/LOCAL GOVT.
I - STUDENT/VOLUNTEER
Z - PUBLIC

17. DUTY STATUS
A - ON DUTY AT FACILITY
B - ON DUTY OFF FACILITY
C - TDY AT FACILITY
D - TDY OFF FACILITY
E - CHANGE OF DUTY
F - OFF DUTY
P - PATIENT
R - VISITOR
Z - NOT APPLICABLE

18. HOURS ON DUTY AT TIME OF ACCIDENT (Fed employees CO's only)

19. EMPLOYEE WORK PHONE

20. SUPERVISOR NAME *(Last, First)* PLEASE PRINT

21. SUPERVISOR LOCATION & PHONE NUMBER

ACCIDENT/INJURY/ILLNESS DATA

22. DATE OF ACCIDENT — Month / Day / Year

23. TIME OF ACCIDENT — 24 HOUR CLOCK

24. STATE

25. ACCIDENT LOCATION *(Include Bldg. & Room Number or outside location)*

26. DESCRIPTION OF ACCIDENT *(Use reverse side for additional space)*

27. NATURE OF INJURY or ILLNESS

28. PART OF BODY

29. SEVERITY OF INJURY/ILLNESS
1. No Treatment Required
2. First Aid Only
3. Medical Treatment Only
4. Occupational Illness
5. Disabling (Temporary)
6. Disabling (Perm. Partial)
7. Disabling (Total)
8. Fatality

30. CULMINATION
1. No Restriction
2. Restricted
3. Temp. Transfer
4. Perm. Transfer
5. Terminated

31. DAYS AT WORK but restricted activity

32. DAYS AWAY FROM WORK Due to Accident

33. WEATHER at time of accident

34. JOB RELATIONSHIP
D - Direct
I - Indirect

35. THIRD PARTY INVOLVED? Y or N

36. RECORDABLE Y or N

37. DATE OF THIS REPORT — Month / Day / Year

38. Completed by *(if other than Supervisor)*

ACCIDENT ANALYSIS DATA

39. CAUSE OF INJURY/ILLNESS *(OWCP Type) See Appendix for additional codes.*
100 - Struck
200 - Fall, Slip, Trip
300 - Caught
400 - Puncture, Cut
500 - Contacted
600 - Exerted
700 - Exposed
800 - Travel
950 - Insufficient Data
999 - NEC

40. ACTIVITY AT TIME OF ACCIDENT

41. SOURCE OF INJURY OR DAMAGE

42. UNSAFE CONDITION

43. UNSAFE ACT

44. CONTRIBUTING FACTOR

45. FIRE Form of Ignition

46. FIRE Type of Material

47. FIRE Form of Material

48. PROPERTY DAMAGED

49. PROPERTY OWNERSHIP

50. AMOUNT OF DAMAGE OR LOSS 00

51. YEAR OF MFG/CONST

52. COULD ACCIDENT HAVE RESULTED IN A MORE SERIOUS INJURY OR LOSS BY A MINOR CHANGE IN TIME OR POSITION? Y or N

53. CORRECTIVE ACTION TAKEN

Explain What Led Up To The Accident. How The Accident Happened. Equipment Failures. Material Defects, Etc. Plus Necessary Sketches or Photographs to make facts clear. (Use Additional Sheets, if Necessary)

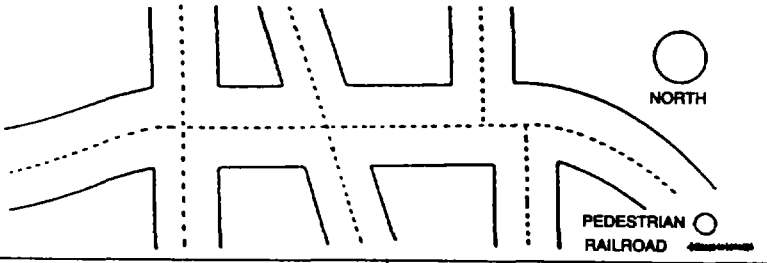
WITNESS: NAME AND ADDRESS:

DRAW A DIAGRAM OR SKETCH OF WHAT HAPPENED:

FOR MOTOR VEHICLE ACCIDENTS:

SHOW VEHICLE AS → AND NUMBER EACH 1

USE SOLID LINE TO SHOW PATH BEFORE ACCIDENT
USE DASHED LINE TO SHOW PATH AFTER ACCIDENT
SHOW DIRECTION OF TRAVEL BY ARROWS
GIVE NAMES OR NUMBERS OF STREETS OR HIGHWAYS



Signature, Address, and Title of Reporting Official		Date:	Phone:
Signature, Address, and Title of Reviewing Authority:		Date:	Phone:
Signature, Address, and Title of Coding Official:		Date:	Phone:
Safety and Occupational Health Office Review:	Agency, Region, or Office:	Date:	Phone:

NOTICE OF CONDITIONS UNDER WHICH THIS INFORMATION IS COLLECTED

In compliance with the Privacy Act of 1974, the following information is provided:

1. Solicitation of the information is authorized by the Occupational Safety and Health Act of 1970 (PL 91-596); 5 USC 7902; 29 CFR 1960; 28 USC 2671-80 and Executive Order 12196 (1 Oct 1980); these authorities do not require that penalties be imposed for failure to respond to this request.
2. The principal purpose for which this information is collected is to provide statistical data and analysis of injury, illness and property loss experience in support of the Departmental, Agency, Region and Staff Office Safety and Health Programs as well as required statistical summations or reports to the Department of Labor and other governmental entities or functions requiring such information.
3. Routine uses of this information include: a) Providing the means for complying with the reporting requirements of the Occupational Safety and Health Act of 1970; 29 CFR 1960; and such other reports as may be required by legislative or regulatory obligations; b) Providing such summary statistical data and analysis as is necessary to appropriately evaluate the effectiveness of the safety management programs and assist appropriate departmental functions in the initiation and support of corrective or preventive action; c) Responding to a court subpoena or court of competent jurisdictions in a criminal or civil suit; and d) Transferring to the appropriate governmental or regulatory entities, whether federal, state, local or foreign, such information as is relevant to investigative action or when a violation or potential violation of a statute or regulation is indicated.
4. The effect on the individual of not providing all or part of the requested information may be to render impossible or to delay the Department's documenting the injury, illness, and/or property loss. Every effort will be made to obtain the factual information relating to an incident from other sources should the individual involved refuse to provide the requested information.

OMB No. 0990-0015
Expiration Date: 11/30/96

DEPARTMENT OF
HEALTH, AND HUMAN SERVICES

REPORT OF ACCOUNTABLE PERSONAL PROPERTY

NOTE: Complete this form in accordance with instructions on reverse side of copy No. 6

1. DATE	2. PUBLIC VOUCHER NO.		
3. CONTRACT NUMBER	4. REPORT NO.	PAGE NO.	NO. PAGES

5. NAME OF PERSON RESPONSIBLE FOR THIS REPORT TELEPHONE: AREA CODE NO.	6. TYPE OF REPORT ☐ ACQUISITION—GOV. TITLED ☐ ACQUISITION—CONTR. TITLED ☐ ANNUAL INVENTORY ☐ FINAL INVENTORY	7. NAME AND ADDRESS OF CONTRACTOR	8. FOR GOV. USE ONLY

9. ITEM NO.	10. DESCRIPTION & NSN	11. GFP OR CAP	12. MFR.	13. MODEL OR TYPE	14. MFR. SERIAL NO.	15. UNIT ACQUISITION COST	16. GOV. ID. NO.	17. ACQ. AUTH.	18. DATE REC'D. MO/YR

19. AUTHENTICATION BY CONTRACTOR'S SUPERVISORY ACCOUNTING OFFICIAL		20. ACCEPTED BY AUTHORIZED GOVERNMENT REPRESENTATIVE	VOUCHER NO.
SIGNATURE	DATE	SIGNATURE AND TITLE	DATE
NAME (TYPED)	TITLE		

HHS 565 (9/92)

INSTRUCTIONS FOR PREPARATION OF HHS FORM 565
REPORT OF ACCOUNTABLE PERSONAL PROPERTY

This report shall be submitted in five copies by the contractor and included with his Public Voucher (or invoice) under which reimbursement for the acquisition of authorized accountable personal property is requested. When utilizing this form for inventory reporting, five copies shall be forwarded to the cognizant Property Administrator. Final inventories must include the Certification required by HHS Contractor's Guide for Control of Government Property.

Item No.

1. Enter date prepared.
2. Enter Public Voucher (or Invoice) Number.
3. Enter complete contract number.
4. Enter number of this report. (Reports will be numbered serially beginning with No. 1 for each contract.) Enter page number and total number of pages.
5. Enter name and telephone number of contractor's representative responsible for report.
6. Indicate type of Report.
7. Enter name and address of contractor exactly as it appears on the contract.
8. Leave blank. For Contracting Agency use only.
9. Enter line item number. Each report shall begin with number "1".

10-14. Identify fully the property being reported, including manufacturer, model, type, capacity, size and serial number. When this form is used for inventory reporting, include condition code in item 10 and indicate GFP or CAP in item 11.

15. Enter unit acquisition cost of the item. (List all taxes, discounts, shipping and installation costs as separate items immediately following each item being reported.)
16. For Government-owned property, enter the Government identification number (decal) affixed. For Contractor-owned property, enter contractor's identification number affixed.
17. Enter authorization for acquisition e.g., contract schedule number, contracting officer's authorization letter number, etc.
18. Enter month and year property was received by contractor as reflected on receiving report.
19. Enter signature and title of person authorized to certify to the accuracy of report.
20. Leave blank. For Contracting Agency use only.

This Form may be reproduced by Contractors in size 8" x 10½" only.

Burden Estimate Statement

Public reporting burden for this collection of information is estimated to vary from 15 minutes to 30 minutes per response, with an average of 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: OS Reports Clearance Officer, Division of Organization and Management Analysis, Room 4300, 330 Independence Avenue SW, Washington, D.C. 20201, and to:

Office of Management and Budget
Paperwork Reduction Project [0990-0081]
Washington D.C. 20503